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Medical records: the first challenge in health care

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Dear editor:

One of the most important documents in patient care is the medical record, since it registers vital facts, attempts to frame the current problem and dictates the principles of patient´s treatment. It also has a research purpose, among others [1]. Since the early years of our academic training, we begin to interact with these documents. Extensive files that sometimes are impenetrable, not only because of the knowledge we have not yet acquired or medical technical language which we still don´t handle, but because of other not medical difficulties (although typical of the guild) such as illegible handwriting, chaotic structure and disorganization. Added to this are the ravages of the passage of time as the natural destruction of written paper.

To read a clinical record in a sheet of paper is a skill coming from the hidden curriculum of medical career. During their training, physicians not only must acquire the ability to execute an assertive and entertaining interview with the patient, along with a complete and directed physical examination, but they must also develop the ability to interpret these sometimes complicated and untranslatable writings. In a sense, it is another semiological ability to be learned, almost as if the clinical history were an extra organ of the patient with a special way to be explored and with secrets, signs and symptoms to be described, as is typical in the heart or liver. Similarly, only time and the daily confrontation make it possible to know it.

Do we consciously register in the medical records the patient's vital information? The answer is unclear in archives where the handwritings of the ward and the emergency physician are indecipherable, where laboratory tests and patient´s progress are mixed up with admission data, and where the findings of the specialists are lost among daily developments.

The current law in Chile (Law 20584) states in its Decree No. 41 that the medical record is that "mandatory instrument in which all the information related to the different areas of the health of patients is registered and serves the purpose of keeping such information integrated, which is necessary for granting health care of patients". Therefore, it is added that "the medical record, whatever its support, must be made clearly and legibly retaining its structure clearly and sequentially" [2].

The truth is that many professionals strive to keep intact clinical records, however, variables such as time spent on patient care, professional fatigue, spelling and personal mental scheme, and useful life of the paper used, among other reasons, could influence against this attempt. In any case, we always should aspire the clinical record to be of the highest possible quality, and not assume that its disorder is a natural product of the many attentions, or whose neatness is not one´s personal responsibility but rather someone else´s. All health professionals are called to care for its order and organization, especially doctors.

The problem of poor quality of medical record on paper is not a minor problem. Studies have shown that the rate of medical errors is higher in hospitals with paper-records compared to electronic files, due to illegibility and wear of the paper. Because of this, important antecedents are overlooked, lost, or unavailable at the time of care. Added to this are the technical difficulties for doing research [3].

It is understandable that the high cost of medical record digitization is a barrier to the implementation of these systems in the public service; however, there are workable measures that could be taken to improve the traditional method of records on paper. Among these are file sorting equipment, default schemes for each service, folders with segments for different types of documents, improving writing, etcetera [4].

The medical record is our working tool, such as the calculator for the engineer or the blackboard for the teacher. It allows coordinated care and facilitates teamwork inside the service, between other hospital services and with other health institutions. It is a most important document

with multiple functions such as teaching, research and economic management, therefore, any action taken to improve them is necessary [3],[5].

Notes

From the editor
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